(b) Support services component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(7)(a) Operations component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, operations component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2004, operations component rate allocations.

(b) Operations component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(8) For July 1, 1998, through September 30, 1998, a facility's property and return on investment component rates shall be the facility's June 30, 1998, property and return on investment component rates, without increase. For October 1, 1998, through June 30, 1999, a facility's property and return on investment component rates shall be rebased utilizing 1997 adjusted cost report data covering at least six months of data.

(9) Total payment rates under the nursing facility medicaid payment system shall not exceed facility rates charged to the general public for comparable services.

(10) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of five dollars and fifteen cents per hour or the federal minimum wage.

(11) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: The need to prorate inflation for partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities banking beds or converting beds back into service, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

(12) The department shall establish in rule procedures, principles, and conditions, including necessary threshold costs, for adjusting rates to reflect capital improvements or new requirements imposed by the department or the federal government. Any such rate adjustments are subject to the provisions of RCW 74.46.421. [1998 c 322 § 19.]

RCW 74.46.441 Public disclosure of rate-setting information. The department shall disclose to any member of the public all rate-setting information consistent with requirements of state and federal laws. [1998 c 322 § 20.]

RCW 74.46.475 Submitted cost report--Analysis and adjustment by department. (1) The department shall analyze the submitted cost report or a portion thereof of each contractor for each report period to determine if the information is correct, complete, reported in conformance with department instructions and generally accepted accounting principles, the requirements of this chapter, and such rules as the department may adopt. If the analysis finds that the cost report is incorrect or incomplete, the department may make adjustments to the reported information for purposes of establishing payment rate allocations. A schedule of such adjustments shall be provided to contractors and shall include an explanation for the adjustment and the dollar amount of the adjustment. Adjustments shall be subject to review and appeal as provided in this chapter.

(2) The department shall accumulate data from properly completed cost reports, in addition to assessment data on each facility's resident population characteristics, for use in:

(a) Exception profiling; and

(b) Establishing rates.

(3) The department may further utilize such accumulated data for analytical, statistical, or informational purposes as necessary. [1998 c 322 § 21; 1985 c 361 § 13; 1983 1st ex.s. c 67 § 23.]

NOTES:

Savings--1985 c 361: See note following RCW 74.46.020.

RCW 74.46.485 Case mix classification methodology. (1) The department shall employ the resource utilization group III case mix classification methodology. The department shall use the forty-four group index maximizing model for the resource utilization group III grouper version 5.10, but the department may revise or update the classification methodology to reflect advances or refinements in resident assessment or classification, subject to federal requirements.

(2) A default case mix group shall be established for cases in which the resident dies or is discharged for any purpose prior to completion of the resident's initial assessment. The default case mix group and case mix weight for these cases shall be designated by the department.

(3) A default case mix group may also be established for cases in which there is an untimely assessment for the resident. The default case mix group and case mix weight for these cases shall be designated by the department. [1998 c 322 § 22.]

RCW 74.46.496 Case mix weights--Determination--Revisions. (1) Each case mix classification group shall be assigned a case mix weight. The case mix weight for each resident of a nursing facility for each calendar quarter shall be based on data from resident assessment instruments completed for the resident and weighted by the number of days the resident was in each case mix classification group. Days shall be counted as provided in this section.

(2) The case mix weights shall be based on the average minutes per registered nurse, licensed practical nurse, and certified nurse aide, for each case mix group, and using the health care financing administration of the United States department of health and human services 1995 nursing facility staff time measurement study stemming from its multistate nursing home case mix and quality demonstration project. Those minutes shall be weighted by state-wide ratios of registered nurse to certified nurse aide, and licensed practical nurse to certified nurse aide, wages, including salaries and benefits, which shall be based on 1995 cost report data for this state.

(3) The case mix weights shall be determined as follows:

(a) Set the certified nurse aide wage weight at 1.000 and calculate wage weights for registered nurse and licensed practical nurse average wages by dividing the certified nurse aide average wage into the registered nurse average wage and licensed practical nurse average wage;

(b) Calculate the total weighted minutes for each case mix group in the resource utilization group III classification system by multiplying the wage weight for each worker classification by the average number of minutes that classification of worker spends caring for a resident in that resource utilization group III classification group, and summing the products;

(c) Assign a case mix weight of 1.000 to the resource utilization group III classification group with the lowest total weighted minutes and calculate case mix weights by dividing the lowest group's total weighted minutes into each group's total weighted minutes and rounding weight calculations to the third decimal place.

(4) The case mix weights in this state may be revised if the health care financing administration updates its nursing facility staff time measurement studies. The case mix weights shall be revised, but only when direct care component rates are cost-rebased as provided in subsection (5) of this section, to be effective on the July 1st effective date of each cost-rebased direct care component rate. However, the department may revise case mix weights more frequently if, and only if, significant variances in wage ratios occur among direct care staff in the different caregiver classifications identified in this section.

(5) Case mix weights shall be revised when direct care component rates are cost-rebased every three years as provided in RCW 74.46.431(4)(a). [1998 c 322 § 23.]

RCW 74.46.501 Average case mix indexes determined quarterly--Facility average case mix index--Medicaid average case mix index. (1) From individual case mix weights for the applicable quarter, the department shall determine two average case mix indexes for each medicaid nursing facility, one for all residents in the facility, known as the facility average case mix index, and one for medicaid residents, known as the medicaid average case mix index.

(2)(a) In calculating a facility's two average case mix indexes for each quarter, the department shall include all residents or medicaid residents, as applicable, who were physically in the facility during the quarter in question (January 1st through March 31st, April 1st through June 30th, July 1st through September 30th, or October 1st through December 31st).

(b) The facility average case mix index shall exclude all default cases as defined in this chapter. However, the medicaid average case mix index shall include all default cases.

(3) Both the facility average and the medicaid average case mix indexes shall be determined by multiplying the case mix weight of each resident, or each medicaid resident, as applicable, by the number of days, as defined in this section and as applicable, the resident was at each particular case mix classification or group, and then averaging.

(4)(a) In determining the number of days a resident is classified into a particular case mix group, the department shall determine a start date for calculating case mix grouping periods as follows:

(i) If a resident's initial assessment for a first stay or a return stay in the nursing facility is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the later of either the first day of the quarter or the resident's facility admission or readmission date;

(ii) If a resident's significant change, quarterly, or annual assessment is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the date the assessment is completed;

(iii) If a resident's significant change, quarterly, or annual assessment is not timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the due date for the assessment.

(b) If state or federal rules require more frequent assessment, the same principles for determining the start date of a resident's classification in a particular case mix group set forth in subsection (4)(a) of this section shall apply.

(c) In calculating the number of days a resident is classified into a particular case mix group, the department shall determine an end date for calculating case mix grouping periods as follows:

(i) If a resident is discharged before the end of the applicable quarter, the end date shall be the day before discharge;

(ii) If a resident is not discharged before the end of the applicable quarter, the end date shall be the last day of the quarter;

(iii) If a new assessment is due for a resident or a new assessment is completed and transmitted to the department, the end date of the previous assessment shall be the earlier of either the day before the assessment is due or the day before the assessment is completed by the nursing facility.

(5) The cutoff date for the department to use resident assessment data, for the purposes of calculating both the facility average and the medicaid average case mix indexes, and for establishing and updating a facility's direct care component rate, shall be one month and one day after the end of the quarter for which the resident assessment data applies.

(6) A threshold of ninety percent, as described and calculated in this subsection, shall be used to determine the case mix index each quarter. The threshold shall also be used to determine which facilities' costs per case mix unit are included in determining the ceiling, floor, and price. If the facility does not meet the ninety percent threshold, the department may use an alternate case mix index to determine the facility average and medicaid average case mix indexes for the quarter. The threshold is a count of unique minimum data set assessments, and it shall include resident assessment instrument tracking forms for residents discharged prior to completing an initial assessment. The threshold is calculated by dividing the count of unique minimum data set assessments by the average census for each facility. A daily census shall

be reported by each nursing facility as it transmits assessment data to the department. The department shall compute a quarterly average census based on the daily census. If no census has been reported by a facility during a specified quarter, then the department shall use the facility's licensed beds as the denominator in computing the threshold.

(7)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the facility average case mix index will be used only every three years in combination with cost report data as specified by RCW 74.46.431 and 74.46.506, to establish a facility's allowable cost per case mix unit. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate quarterly.

(b) The facility average case mix index used to establish each nursing facility's direct care component rate shall be based on an average of calendar quarters of the facility's average case mix indexes.

(i) For October 1, 1998, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1997.

(ii) For July 1, 2001, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1999.

(c) The medicaid average case mix index used to update or recalibrate a nursing facility's direct care component rate quarterly shall be from the calendar quarter commencing six months prior to the effective date of the quarterly rate. For example, October 1, 1998, through December 31, 1998, direct care component rates shall utilize case mix averages from the April 1, 1998, through June 30, 1998, calendar quarter, and so forth. [1998 c 322 § 24.]

RCW 74.46.506 Direct care component rate allocations--Determination--Quarterly updates--Fines. (1) The direct care component rate allocation corresponds to the provision of nursing care for one resident of a nursing facility for one day, including direct care supplies. Therapy services and supplies, which correspond to the therapy care component rate, shall be excluded. The direct care component rate includes elements of case mix determined consistent with the principles of this section and other applicable provisions of this chapter.

(2) Beginning October 1, 1998, the department shall determine and update quarterly for each nursing facility serving medicaid residents a facility-specific per-resident day direct care component rate allocation, to be effective on the first day of each calendar quarter. In determining direct care component rates the department shall utilize, as specified in this section, minimum data set resident assessment data for each resident of the facility, as transmitted to, and if necessary corrected by, the department in the resident assessment instrument format approved by federal authorities for use in this state.

(3) The department may question the accuracy of assessment data for any resident and utilize corrected or substitute information, however derived, in determining direct care component rates. The department is authorized to impose civil fines and to take adverse rate actions against a contractor, as specified by the department in rule, in order to obtain compliance with resident assessment and data transmission requirements and to ensure accuracy.

(4) Cost report data used in setting direct care component rate allocations shall be 1996 and 1999, for rate periods as specified in RCW 74.46.431(4)(a).

(5) Beginning October 1, 1998, the department shall rebase each nursing facility's direct care component rate allocation as described in RCW 74.46.431, adjust its direct care component rate allocation for economic trends and conditions as described in RCW 74.46.431, and update its medicaid average case mix index, consistent with the following:

(a) Reduce total direct care costs reported by each nursing facility for the applicable cost report period specified in RCW 74.46.431(4)(a) to reflect any department adjustments, and to eliminate reported resident therapy costs and adjustments, in order to derive the facility's total allowable direct care cost;

(b) Divide each facility's total allowable direct care cost by its adjusted resident days for the same report period, increased if necessary to a minimum occupancy of eighty-five percent; that is, the greater of actual or imputed occupancy at eighty-five percent of licensed beds, to derive the facility's allowable direct care cost per resident day;

(c) Adjust the facility's per resident day direct care cost by the applicable factor specified in RCW 74.46.431(4)(b) and (c) to derive its adjusted allowable direct care cost per resident day;

(d) Divide each facility's adjusted allowable direct care cost per resident day by the facility average case mix index for the applicable quarters specified by RCW 74.46.501(7)(b) to derive the facility's allowable direct care cost per case mix unit;

(e) Divide nursing facilities into two peer groups: Those located in metropolitan statistical areas as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government, and those not located in a metropolitan statistical area;

(f) Array separately the allowable direct care cost per case mix unit for all metropolitan statistical area and for all nonmetropolitan statistical area facilities, and determine the median allowable direct care cost per case mix unit for each peer group;

(g) Except as provided in (k) of this subsection, from October 1, 1998, through June 30, 2000, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than eighty-five percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to eighty-five percent of the facility's peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred fifteen percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred fifteen percent of the peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between eighty-five and one hundred fifteen percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(h) Except as provided in (k) of this subsection, from July 1, 2000, through June 30, 2002, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than ninety percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to ninety percent of the facility's peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred ten percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred ten percent of the peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between ninety and one hundred ten percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(i) From July 1, 2002, through June 30, 2004, determine each facility's quarterly direct care component rate as follows:

(i) Any facility whose allowable cost per case mix unit is less than ninety-five percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to ninety-five percent of the facility's peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred five percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred five percent of the peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between ninety-five and one hundred five percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(j) Beginning July 1, 2004, determine each facility's quarterly direct care component rate by multiplying the facility's peer group median allowable direct care cost per case mix unit by that facility's medicaid average case mix index from the applicable quarter as specified in RCW 74.46.501(7)(c).

(k)(i) Between October 1, 1998, and June 30, 2000, the department shall compare each facility's direct care component rate allocation calculated under (g) of this subsection with the facility's nursing services component rate in effect on June 30, 1998, less therapy costs, plus any exceptional care offsets as reported on the cost report, adjusted for economic trends and conditions as provided in RCW 74.46.431. A facility shall receive the higher of the two rates;

(ii) Between July 1, 2000, and June 30, 2002, the department shall compare each facility's direct care component rate allocation calculated under (h) of this subsection with the facility's direct care component rate in effect on June 30, 2000. A facility shall receive the higher of the two rates.

(6) The direct care component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively. [1998 c 322 § 25.]

RCW 74.46.511 Therapy care component rate allocation--Determination. (1) The therapy care component rate allocation corresponds to the provision of medicaid one-on-one therapy provided by a qualified therapist as defined in this chapter, including therapy supplies and therapy consultation, for one day for one medicaid resident of a nursing facility. The therapy care component rate allocation for October 1, 1998, through June 30, 2001, shall be based on adjusted therapy costs and days from calendar year 1996. The therapy component rate allocation for July 1, 2001, through June 30, 2004, shall be based on adjusted therapy costs and days from calendar year 1999. The therapy care component rate shall be adjusted for economic trends and conditions as specified in RCW 74.46.431(5)(b), and shall be determined in accordance with this section.

(2) In rebasing, as provided in RCW 74.46.431(5)(a), the department shall take from the cost reports of facilities the following reported information:

(a) Direct one-on-one therapy charges for all residents by payer including charges for supplies;

(b) The total units or modules of therapy care for all residents by type of therapy provided, for example, speech or physical. A unit or module of therapy care is considered to be fifteen minutes of one-on-one therapy provided by a qualified therapist or support personnel; and

(c) Therapy consulting expenses for all residents.

(3) The department shall determine for all residents the total cost per unit of therapy for each type of therapy by dividing the total adjusted one-on-one therapy expense for each type by the total units provided for that therapy type.

(4) The department shall divide medicaid nursing facilities in this state into two peer groups:

(a) Those facilities located within a metropolitan statistical area; and

(b) Those not located in a metropolitan statistical area.

Metropolitan statistical areas and nonmetropolitan statistical areas shall be as determined by the United States office of management and budget or other applicable federal office. The department shall array the facilities in each peer group from highest to lowest based on their total cost per unit of therapy for each therapy type. The department shall determine the median total cost per unit of therapy for each therapy type and add ten percent of median total cost per unit of therapy. The cost per unit of therapy for each therapy type at a nursing facility shall be the lesser of its cost per unit of therapy for each therapy type or the median total cost per unit plus ten percent for each therapy type for its peer group.

(5) The department shall calculate each nursing facility's therapy care component rate allocation as follows:

(a) To determine the allowable total therapy cost for each therapy type, the allowable cost per unit of therapy for each type of therapy shall be multiplied by the total therapy units for each type of therapy;

(b) The medicaid allowable one-on-one therapy expense shall be calculated taking the allowable total therapy cost for each therapy type times the medicaid percent of total therapy charges for each therapy type;

(c) The medicaid allowable one-on-one therapy expense for each therapy type shall be divided by total adjusted medicaid days to arrive at the medicaid one-on-one therapy cost per patient day for each therapy type;

(d) The medicaid one-on-one therapy cost per patient day for each therapy type shall be multiplied by total adjusted patient days for all residents to calculate the total allowable one-on-one therapy expense. The lesser of the total allowable therapy consultant expense for the therapy type or a reasonable percentage of allowable therapy consultant expense for each therapy type, as established in rule by the department, shall be added to the total allowable one-on-one therapy expense to determine the allowable therapy cost for each therapy type;

(e) The allowable therapy cost for each therapy type shall be added together, the sum of which shall be the total allowable therapy expense for the nursing facility;

(f) The total allowable therapy expense will be divided by the greater of adjusted total patient days from the cost report on which the therapy expenses were reported, or patient days at eighty-five percent occupancy of licensed beds. The outcome shall be the nursing facility's therapy care component rate allocation.

(6) The therapy care component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively. [1998 c 322 § 26.]

RCW 74.46.515 Support services component rate allocation--Determination. (1) The support services component rate allocation corresponds to the provision of food, food preparation, dietary, housekeeping, and laundry services for one resident for one day.

(2) Beginning October 1, 1998, the department shall determine each medicaid nursing facility's support services component rate allocation using cost report data specified by RCW 74.46.431(6).

(3) To determine each facility's support services component rate allocation, the department shall:

(a) Array facilities' adjusted support services costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within a metropolitan statistical area, and for those not located in any metropolitan statistical area and determine the median adjusted cost for each peer group;

(b) Set each facility's support services component rate at the lower of the facility's per resident day adjusted support services costs from the applicable cost report period or the adjusted median per resident day support services cost for that facility's peer group, either metropolitan statistical area or nonmetropolitan statistical area, plus ten percent; and

(c) Adjust each facility's support services component rate for economic trends and conditions as provided in RCW 74.46.431(6).

(4) The support services component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively. [1998 c 322 § 27.]

RCW 74.46.521 Operations component rate allocation--Determination. (1) The operations component rate allocation corresponds to the general operation of a nursing facility for one resident for one day, including but not limited to management, administration, utilities, office supplies, accounting and bookkeeping, minor building maintenance, minor equipment repairs and replacements, and other supplies and services, exclusive of direct care, therapy care, support services, property, and return on investment.

(2) Beginning October 1, 1998, the department shall determine each medicaid nursing facility's operations component rate allocation using cost report data specified by RCW 74.46.431(7)(a).

(3) To determine each facility's operations component rate the department shall:

(a) Array facilities' adjusted general operations costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within a metropolitan statistical area and for those not located in a metropolitan statistical area and determine the median adjusted cost for each peer group;

(b) Set each facility's operations component rate at the lower of the facility's per resident day adjusted operations costs from the applicable cost report period or the adjusted median per resident day general operations cost for that facility's peer group, metropolitan statistical area or nonmetropolitan statistical area; and

(c) Adjust each facility's operations component rate for economic trends and conditions as provided in RCW 74.46.431(7)(b).

(4) The operations component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421. If the department determines that the weighted average rate allocations for all rate components for all facilities is likely to exceed the weighted average total rate specified in the state biennial appropriations act, the department shall adjust the rate allocations calculated in this section proportional to the amount by which the total weighted average rate allocations would otherwise exceed the budgeted level. Such adjustments shall only be made prospectively, not retrospectively. [1998 c 322 § 28.]

RCW 74.46.531 Department may adjust component rates--Contractor may request--Errors or omissions. (1) The department may adjust component rates for errors or omissions made in establishing component rates and determine amounts either overpaid to the contractor or underpaid by the department.

(2) A contractor may request the department to adjust its component rates because of:

(a) An error or omission the contractor made in completing a cost report; or

(b) An alleged error or omission made by the department in determining one or more of the contractor's component rates.

(3) A request for a rate adjustment made on incorrect cost reporting must be accompanied by the amended cost report pages prepared in accordance with the department's written instructions and by a written explanation of the error or omission and the necessity for the amended cost report pages and the rate adjustment.

(4) The department shall review a contractor's request for a rate adjustment because of an alleged error or omission, even if the time period has expired in which the contractor must appeal the rate when initially issued, pursuant to rules adopted by the department under RCW 74.46.780. If the request is

received after this time period, the department has the authority to correct the rate if it agrees an error or omission was committed. However, if the request is denied, the contractor shall not be entitled to any appeals or exception review procedure that the department may adopt under RCW 74.46.780.

(5) The department shall notify the contractor of the amount of the overpayment to be recovered or additional payment to be made to the contractor reflecting a rate adjustment to correct an error or omission. The recovery from the contractor of the overpayment or the additional payment to the contractor shall be governed by the reconciliation, settlement, security, and recovery processes set forth in this chapter and by rules adopted by the department in accordance with this chapter.

(6) Component rate adjustments approved in accordance with this section are subject to the provisions of RCW 74.46.421. [1998 c 322 § 31.]

PART F
BILLING/PAYMENT

RCW 74.46.600 Billing period. A contractor shall bill the department for care provided to medical care recipients from the first through the last day of each calendar month. [1980 c 177 § 60.]

RCW 74.46.610 Billing procedure--Rules. (1) A contractor shall bill the department each month by completing and returning a facility billing statement as provided by the department. The statement shall be completed and filed in accordance with rules established by the department.

(2) A facility shall not bill the department for service provided to a recipient until an award letter of eligibility of such recipient under rules established under chapter 74.09 RCW has been received by the facility. However a facility may bill and shall be reimbursed for all medical care recipients referred to the facility by the department prior to the receipt of the award letter of eligibility or the denial of such eligibility.

(3) Billing shall cover the patient days of care. [1998 c 322 § 32; 1983 1st ex.s. c 67 § 33; 1980 c 177 § 61.]

RCW 74.46.620 Payment. (1) The department will pay a contractor for service rendered under the facility contract and billed in accordance with RCW 74.46.610.

(2) The amount paid will be computed using the appropriate rates assigned to the contractor.

(3) For each recipient, the department will pay an amount equal to the appropriate rates, multiplied by the number of medicaid resident days each rate was in effect, less the amount the recipient is required to pay for his or her care as set forth by RCW 74.46.630. [1998 c 322 § 33; 1980 c 177 § 62.]

RCW 74.46.630 Charges to patients. (1) The department will notify a contractor of the amount each medical care recipient is required to pay for care provided under the contract and the effective date of such required contribution. It is the contractor's responsibility to collect that portion of the cost of care from the patient, and to account for any authorized reduction from his or her contribution in accordance with rules established by the department.

(2) If a contractor receives documentation showing a change in the income or resources of a recipient which will mean a change in his or her contribution toward the cost of care, this shall be reported in writing to the department within seventy-two hours and in a manner specified by rules established by the department. If necessary, appropriate corrections will be made in the next facility statement, and a copy of documentation supporting the change will be attached. If increased funds for a recipient are received by a contractor, an amount determined by the department shall be allowed for clothing and personal and incidental expense, and the balance applied to the cost of care.

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(3) The contractor shall accept the payment rates established by the department as full compensation for all services provided under the contract, certification as specified by Title XIX, and licensure under chapter 18.51 RCW. The contractor shall not seek or accept additional compensation from or on behalf of a recipient for any or all such services. [1998 c 322 § 34; 1980 c 177 § 63.]

RCW 74.46.640 Suspension of payments. (1) Payments to a contractor may be withheld by the department in each of the following circumstances:

(a) A required report is not properly completed and filed by the contractor within the appropriate time period, including any approved extension. Payments will be released as soon as a properly completed report is received;

(b) State auditors, department auditors, or authorized personnel in the course of their duties are refused access to a nursing facility or are not provided with existing appropriate records. Payments will be released as soon as such access or records are provided;

(c) A refund in connection with a settlement or rate adjustment is not paid by the contractor when due. The amount withheld will be limited to the unpaid amount of the refund and any accumulated interest owed to the department as authorized by this chapter;

(d) Payment for the final sixty days of service prior to termination or assignment of a contract will be held in the absence of adequate alternate security acceptable to the department pending settlement of all periods when the contract is terminated or assigned; and

(e) Payment for services at any time during the contract period in the absence of adequate alternate security acceptable to the department, if a contractor's net medicaid overpayment liability for one or more nursing facilities or other debt to the department, as determined by settlement, civil fines imposed by the department, third-party liabilities or other source, reaches or exceeds fifty thousand dollars, whether subject to good faith dispute or not, and for each subsequent increase in liability reaching or exceeding twenty-five thousand dollars. Payments will be released as soon as practicable after acceptable security is provided or refund to the department is made.

(2) No payment will be withheld until written notification of the suspension is provided to the contractor, stating the reason for the withholding, except that neither a timely filed request to pursue any administrative appeals or exception procedure that the department may establish by rule nor commencement of judicial review, as may be available to the contractor in law, shall delay suspension of payment. [1998 c 322 § 35; 1995 1st sp.s. c 18 § 112; 1983 1st ex.s. c 67 § 34; 1980 c 177 § 64.]

NOTES:

Conflict with federal requirements--Severability--Effective date--1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

RCW 74.46.650 Termination of payments. All payments to a contractor will end no later than sixty days after any of the following occurs:

(1) A contract is terminated, assigned, or is not renewed;

(2) A facility license is revoked; or

(3) A facility is decertified as a Title XIX facility; except that, in situations where the department determines that residents must remain in such facility for a longer period because of the resident's health or safety, payments for such residents shall continue. [1998 c 322 § 36; 1980 c 177 § 65.]

PART G
ADMINISTRATION